Déjà Vu

Twenty-first century healthcare reforms and post-war urban renewal

David Zigmond

Two large reforming movements in recent history have lost their human sense as they have gained momentum. What did they overlook? What can we learn?

The disadvantage of men not knowing the past is that they do not know the present. History is a hill or high point of vantage, from which alone men see the town in which they live or the age in which they are living.

– GK Chesterton (1933), *All I Survey*

We talk so often now of our NHS being 'in crisis' and 'at breaking point' that the alarms are becoming paradoxically monotonous, a kind of stressed and shredded yet stable backcloth. Like Londoners in the Blitz, we somehow carry on among the casualties and damage: we adapt, and most survive.

There is an overwhelming majority who wish our NHS not only to survive – but to do so in a way that is sustainable, competent, compassionate and convivial. But there is also a clandestine yet powerful minority who do not share this – mostly these are people and organisations that will profiteer from any privatisation of healthcare.[1]

So, most of us want to keep our health service itself in a state of good health. Yet we are seeing how this is an increasingly difficult problem with our ever-expanding population, longevity, technological advances and options. So the expectations, demands and expenses rise, too. How to contain and guide all this? In come our relays of researchers, planners and managers placed to make *efficiency changes*, to *modernise*. In the last two decades the strategies of advance have been broadly those of two complementary kinds: (i) the *4Cs*: competition, commodification, commercialisation and computerisation and (ii) the *REMIC* culture: remote management, inspection and compliance. Yet these modernisation imperatives are

now being shown, increasingly, to be themselves unsustainably expensive in not just financial terms, but in human ones, too.

What is happening? How can devices for our common benefit turn harmful?

If we look back several decades, our history can offer much instruction.

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At the end of World War Two there was, of course, massive damage to urban environments and their populations. Millions of survivors needed reconstruction of their cities and rebuilding of homes. The organisational and financial challenges were vast, but so too were the opportunities for new ideas, businesses and technologies. Visionaries, entrepreneurs and modernisers would rarely get such opportunities: the bombsite became a *tabula rasa* for a new world. From the ashes of recent terrible history a phoenix of fresh ideas and hope would come with our rebuilt cities – our future.

Yet, almost perversely, certainly paradoxically, the most potent and determined initiatives to restructure cities did not come in war-ravaged nations. It arose in the USA, the only combatant to suffer no city damage and the only country to end the war wealthier than before. Despite this apparently unlikely culture-medium this is where the most zealous, articulate and influential city-moderniser operated. Specifically, initially, in New York. The revolution in environmental thinking there would massively and ineradicably transform both that great city and then almost

every other major city in the USA soon after. The human *force majeure* – most revolutions need one – was an urban-planner named Robert Moses.

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I raise my stein to the builder who can remove ghettos without removing people, as I hail the chef who can make omelettes without breaking eggs.

– Robert Moses (1888-1981)

I had not heard of Robert Moses until recently. This now disquiets me, as a brief investigation[2,3,4,5] shows his enormous influence on the lives of millions of city-dwellers in the last fifty years: most conspicuously and first in the USA, but then echoing and amplifying across the decades and throughout the world. China now has the latest crop of Moses-conceived and germinated cities. So Moses' historical importance is huge, yet not now much publicly recognised. This illustrates, I think, a sobering fact of how faces and names may largely vanish but legacies – good and bad – go on, to thrive anonymously and even unconsciously.

But the story of Robert Moses – his character, his thinking, his actions and his legacy – tells us much more than about one particular and remarkable man. For, in many

ways, Moses is a *Zeitgeist* figure: his life is a microcosm of our age – its unstoppable brilliance and cursed follies. For us this is especially evident in our NHS healthcare where, many decades after Moses' nemesis, we are repeating very similar errors, with equivalent damage.

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Moses' power and influence in urban planning grew and spread through the 1930s until the end of the 1960s. He was a forceful, determined, articulate man with a deep and quick understanding of the law, realpolitik and engineering. He knew how to work people, too: his wealth and education gave him a paternalistic mien, a patrician sense of entitlement, and a sophist's power of conversion.

His earliest public work is now seen as benign. He assured beaches and parks for public use, designed and built unprecedently large stadiums, swimming pools and then Parkways – landscaped and curved roads with aesthetic and environmental sympathy.

But after the War the gearing, ethos and his work changes. Rather than providing the population with what he thinks they might want, he is now determined to push through what he *knows* they need: *his* view of modernisation is the only answer.

Moses had become an ideological acolyte of Le Corbusier, an urban planner-philosopher who preached an uncompromising form of functionalism and talked of buildings as 'machines for living'. This machine iconography seems to determine their view of humans, too. Their view of city life is one of a planned and managed network of myriad machines-within-machines.

Neither Moses nor Le Corbusier were much interested in the internal or social life of people, and avoided hearing from anyone who was not useful to them. They saw their own mission, rather, as expert and executive planning for the environment and behaviour of those other people. This could be done remotely by executive decree. They, the experts, knew best.

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The urge to save humanity is almost always only a false-face for the urge to rule it.

– HL Mencken (1956), *The Minority Report*

In the late 1940s Moses consolidated his patrician confidence into an expanding empire of influence. He plotted and manoeuvred himself into several unelected positions of power. He exemplified the timeless power-broker, becoming

increasingly dictatorial in his machinations and intolerant in his manner. To one quietly questioning journalist he angrily retorts: '*If the ends don't justify the means, what does?'* This did not signal a real question, rather his ending the interview.

So, what were these 'means and ends'? And what became of them?

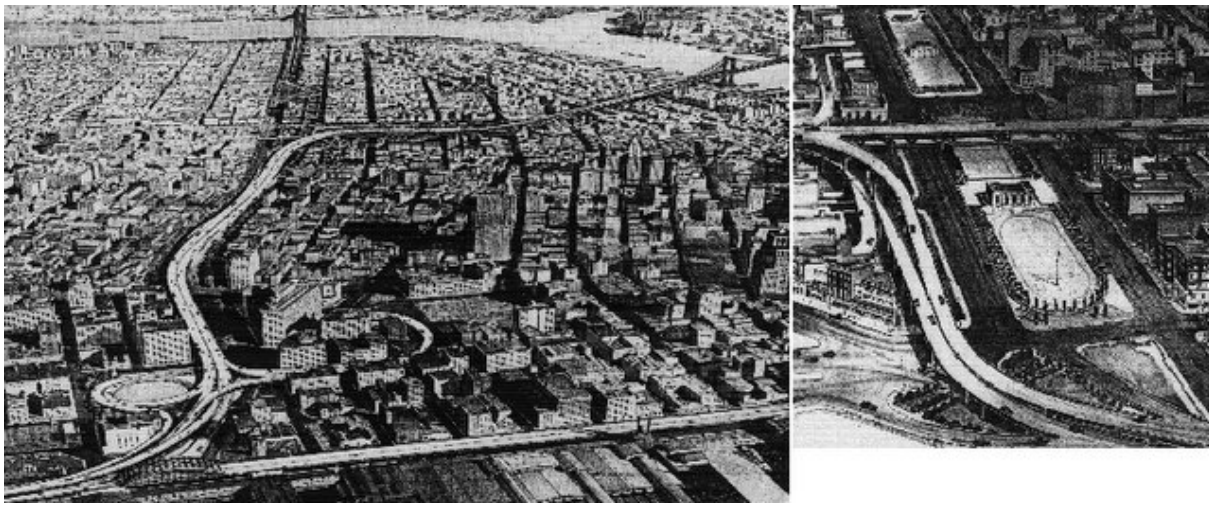
To answer these questions we must return to Moses: his values and views. Moses hated what he saw as the inefficient, ugly, poverty-blighted, untidily illogical sprawl of New York and kindred cities. Millions were densely housed in rundown turn-of-century tenement blocks which coagulated into localities of deprivation: ghettos.

Moses' impatient vision simultaneously surveyed the small and congested roads that ran between these old buildings. They were narrow, short and already inadequate, so the inevitability – and (for Moses) desirability – of increased car use would only worsen the situation.

What was to be done? Moses had no doubt, and his answers become pugnaciously and rapidly clear. He understood the ghettos to be '*like infected or cancerous tissues in our city … the only solution is to take a knife and carve them out. That's progress. I'm sorry if some people are upset, but they are irrelevant. We must do what has to be done … These people need to be rehoused in purpose-built blocks with light and modern utilities and designated recreational areas. That is what we are doing, building them better lives.'*[4]

So started the largest peacetime city-renewal project of all time. The demolition of thousands of old tenement blocks speedily erased from view (but relocated) the slum poverty-traps that so offended Moses. The clearance also enabled his civic-surgical teams to carve out wide,

straight, multi-laned, fast Freeways (not Parkways) to cleanly intersect the City. The ubiquity and supremacy of the car was crucial to this vision of modernity.



To the credulously optimistic, Moses initially seemed like a saviour-surgeon: they would be spared a much worse fate, and then a much brighter future beckoned.

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Mostly the outcome was very different. If we pursue the surgical analogy we can see how Moses, the rhetorically confident civic-surgeon, boldly and accurately follows his (own) surgical technique, his incisions and excisions. But, as in pre-anaesthetic times, the patient is screaming and flailing, so has to be muted and restrained: the surgeon knows best and must continue.

By Moses' own criteria his several operations were successful in technique, but the patients (the cities) did not do well; mostly they were further handicapped by surgical sequelae: continuing haemorrhage, secondary infection, irreparable nerve

damage … all are apt metaphors for the long and stormy post-operative course for his patient-cities. We are still struggling with that damage, several decades later.

So what happened?

Well, *architecturally*, structurally, the plan worked: the old slum-dwellings were cleared and networks of Freeways and breathtaking bridges could traverse the cities without hindrance. So poverty could now not be seen, the city looked tidier and the motorist – the renaissance urbanite – was not impeded about his business.

But *humanly*, functionally, the plan caused much emotional and social dislocation and damage that could not be solved. Poor people were moved involuntarily into densely-trafficked road-ringed clusters of tower blocks, now isolated from separately designated recreational and work areas. They were mostly not grateful and happy, but increasingly and chronically disturbed and distressed. This became evident by multiple measurable parameters: long-term unemployment, major mental and physical illness, violent and delinquent crime, drug and alcohol addiction, self-harm and suicide, vandalism (surely an environmental projection of impotent frustration and self-harm) … all ballooned dramatically.

Early predictions or warnings of this were avoided or muted. '*People are stupid. They just don't do what's best for them*' said one glumly defensive City Hall official at a press conference.[4]

Not even the holy-car benefited. The new Freeways were far from free: despite being tolled they nevertheless enticed saturation level traffic and a new level of jams and exhaust pollution. Moses' antipathy to subways and public transport compounded the problems. The poor were further marooned.

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Even if we assume Moses' (and the thousands of modernist reformers') good intent, what were their errors of assumption? And how may we explain them? Moses' character and oversights are well documented and can help us understand what happened. We can see, too, how the story and legacy of this remarkable and powerful man tells us also about our culture's vulnerabilities and conceits: Moses personified so much of what we continue to struggle with in human nature and organisations: the corruption of power, the overreach of mission, the denial of human complexity and diversity, the paradoxical blindness of expert specialists, the oligarchic drift of committees, the remoteness of management … all were enacted in this large-scale saga.

Now fundamental to Moses' errors was his inability or disinclination to see or understand human relationships or meaning: his brilliant abilities in law and engineering could take him only to the limits of the rational, the instrumental and the avowedly intentional. He seems not to have been at all interested in what goes

on between people to make personal bonds and, eventually, communities. And usually the humanly richest communities develop outside executive design or intent.

So he saw in the ghettos only poor, ill-attired people living in grimy buildings and not engaged in the kind of work or activities he could identify with. He did not seem to register the human engagement and animation that thrived on the sidewalks: the chanting street vendors, tenement dwellers calling out of windows to family members below, frissoned interchanges of flirtatious youth, hula-hooping girls in one corner and boys kicking a football around an improvised goal in another, a neighbour's dog bounding with affectionate familiarity to a frail old lady who pats it to bring them both comfort, erranded small children earnestly missioned to their small locality corner store. The residents here are the street's proprietors. '*When our eyes are on the street, we are all safe to walk along it'* one Latino ghettoist says with robust pride.[4]

Such are typical samples of life-expressive, life-sustaining types of city community existence where the environment offers the kind of scale, belonging, stability and space to allow for a sense of the vernacular, the familiar and the personally diverse that bridges our common humanity. All these are human needs and creations. This means they must grow naturally. They cannot be directly designed or manufactured – though our most humane architecture and planning address this very delicate task very deliberately: respectful of how to best to be receptive and protective of these possibilities.

Moses and the many that followed him did not rise to the subtlety of this task because they would not, or could not, understand certain crucial distinctions: the explicit *v* the implicit, the centrality of diversity to coherent community vitality, how systems may (attempt to) control but cannot understand, how the whole is more than the sum of its parts…

A good example of Moses' bias and limitation of view was his insistent plan that those displaced from their fraternal, unsightly (to Moses) low-rise tenements should be moved – despite their clear protest – to regimentally ordered, enormous high-rise blocks. He did not understand that people affiliate and connect naturally horizontally, but not vertically.

The human cost of engineering humans in this way is vast and has already been portrayed. Despite the belated recognition of this, and the subsequent demolition of thousands of tower-blocks in the USA, Moses' doctrines are relaunched now in the 'developing' countries. China is an obvious example. But every human cost, of course, must incur an economic one in each community. Yes, homogoneic tower blocks may be cheap and quick to construct, but their ultimate price is much higher.[9]

This brings me to the distinction of art and science in our attempts to understand the human world and any initiatives to be 'helpful'. Moses probably thought of himself as a *scientist*: he engaged with the world (and those around him) as an expert authority whose objective knowledge – especially of engineering and the law – mandated his remedies for the people. He *knew* what was right: other kinds of understanding were therefore irrelevant impediments. He would fix things. People should move aside.

Moses thus had little interest in the *art* of human care and welfare – the more open discourses we may have with others: being receptive to the complexly ambiguous, the implicit and the semiotic in our fellows. These are the interstices and gravitational fields between us. Deduction may take us so far, imagination will take us far further. This was the realm Moses recurrently and contemptuously dismissed when others attempted to point it out to him. It is why he saw on the tenemented sidewalks only unsightly human poverty to be cleared and fixed, not diverse human richness to be protected and understood. He was interested in industrial manufacture, not natural evolution.

Had Moses allowed a chink in his formidable ideological armour he might have glimpsed early attempts to scientifically document and comprehend such community meaning and cohesion in very poor but stable city localities.[5,6] But he probably regarded such sociology as too soft to merit his serious attention.

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Moses' great personal gifts and flaws became part of the modernist urban renewal programmes: his character templated a culture. So the limitations of this one man, and then his massively wide and long influence, still shape the world we live in today. And this has become relayed, over decades, to the apparently distant world of NHS Healthcare. Let us return there.

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The evolution of our NHS in the last two decades bears a strong resemblance to Moses' modernist cities. This is evident first in the nature and rhetoric of the guiding logic, and then in the inevitably perverse outcomes.

Yet we should first recognise enduring and conspicuous successes of Moses' large projects, for they have their equivalents in our public health. New York's massive bridges and the United Nations building; the virtual elimination of certain dangerous infectious diseases by mass vaccination programmes, the drastic reduction of severe sequelae from Type I Diabetes – all of these we owe to advances in technology geared to mass production, monitoring and compliance. All share the methods, and then the blessings, of such modernism.

But the emergent tangled problems we struggle with also have such similarity. Moses, so brilliant in his vision of large structures, became ever-more impoverished in his view of people. Likewise, in our healthcare we have become best in large-scale management projects. But this is costly, for it has become broadly true that as our technology has become much better, our relationships are frequently worse. Technical treatments advance apace, leaving behind personal care, which dwindles

almost to extinction. So, for example, if you have an acute coronary event, your probable speedy treatment is likely to succeed in a way unimaginable a few decades ago. But if you are bereaved, elderly and lonely with inevitably unravelling health, it is very different. It is increasingly unlikely that you will receive nuanced personal continuity of care: for example, to be tended by a family doctor who has witnessed much of your life, implicitly understands your nature, and whose mere familiarity offers containment and reassurance. You are unlikely to be greeted by a receptionist whose caring, personal recognition and interchange already feels therapeutic. Instead, our bustling and busy staff will now probably be spending much time looking at the computer. Very likely you will leave and not know their name, and they will not remember you.

Yet these are the type of interchanges that provide the kind of 'cement' that holds together *pastoral healthcare*. Pastoral healthcare is the skilled guidance, containment and comfort we offer for all those afflictions that cannot be completely, rapidly and reliably eliminated by pure technology. It is about caring rather than curing. This vast aspect of healthcare remains relatively resistant to our efficient systems and scientific methods that are often so helpful elsewhere. In pastoral healthcare[7] we need sidewalks, not Freeways: we need the smallness of scale and familiarity of contact that can make for relationships and communities.

And it is not just patients and their nearest-and-dearest who are damaged by the loss of the smaller-scale, less centrally schematised ways of working and relating. Experienced healthcarers of many different kinds – GPs, hospital specialists and nurses, psychiatrists and psychologists, community nurses, receptionists – all lament the loss of personal relationships, informally trusting bonds, personal

understandings and affections that – irreplaceably – make for the human warmth, light and sense that make our difficult work not just bearable and sustainable, but creative and gratifying.

The neglect, or even destruction, of these things is what has contributed – in my view, more than anything else – to the current and rampant discontent in our NHS workforce and, more widely, throughout our welfare services. Just as tower-blocked citizens show symptoms of personal and community disintegration, our healthcarers now suffer equivalent malaise – the statistics of rising levels of illness, career abandonment, addictions, litigation, marital breakdown and suicide are chillingly reminiscent of the victims of zealous and humanly-stupidified city planning.

The generating forces of these kindred and massed misfortunes are similar in the righteous sense of the planners and legislators: that the only way to better lives is through greater efficiency, and the way to greater efficiency is through better systems, and the only way to better systems is to manage people more.

But the life of sidewalks or 'therapeutic relationships' cannot be so efficiency-driven or directly controlled. Indeed, the growth of personal trust, understanding or care between people is often inversely proportional to any attempt to directly manage them.

The oversight of this is crucial to our current misdirection.

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Just as Freeways divided and then destroyed natural neighbourly relationships in cities, so the rigidly, often commercially, fragmented NHS has destroyed colleagueial and fraternal professional relationships. Likewise our generic and institutional 'care pathways' frequently eliminate intelligent personal care.

Moses was deeply resistant to the evidence that modernly-convenienced tower-packed residents were unprecendently lonely and looked out to a world they saw as impenetrably alien and inhuman. '*Not at all'*, he growled forewarningly. '*I can't see what they'd be unhappy about*.'[4]

Our successive healthcare reforms are turning out more and more like Moses' urban renewal mission. Both patients and healthcarers are – comparatively, historically – well-convenienced and well-systemed, yet increasingly without human sense or connection. Metaphorically they are 'tower-blocked'. At the time of writing doctors and nurses are both verbally and non-verbally expressing such growing alienation and dissatisfaction. As with many complex relationship problems it is easiest to argue about money. The current Health Secretary there senses firmer ground and so digs in. He effectively says: 'They [healthcarers] are paid fairly and contractually. Government subsidies are most generous. They have nothing to complain about.'

To me, now, he sounds like Moses.

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So, more specifically, what has been lost in our modernisation programmes? And what do we need to restore? While analytical detail is necessary to project these

arguments, it is cumbersome for this narrative. The questions are best annexed to an extended footnote.[8]

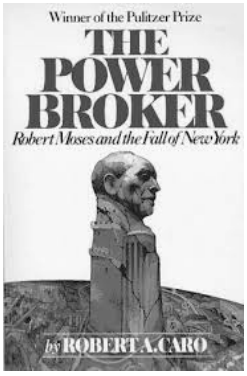
Perhaps we can best finish here, returning to GK Chesterton. He wrote this in his eighty-first year. Moses, a much younger man, was then at the threshold of great power:

Men reform a thing by removing the reality from it, and then do not know what to do with the unreality that is left.

– GK Chesterton (1928). *Generally Speaking*

References and footnotes

1. *NHS For Sale. Myths, Lies and Deception.* Davis, Jacky and Lister, John (2015)
2. The Internet is replete with archived documents, audio and video interviews, academic analysis, journalistic interviews and stories. Wikipedia is especially detailed. The reasons for this profusion are Moses' public importance and his eagerness to procure power, prominence and influence by all available means via the new broadcast media – first radio and then television. This was the case for more than forty years.
3. *The Power Broker. Robert Moses and the Fall of New York*. Caro, Robert (1974)



This is an enduringly acclaimed, award-winning biography of the man, his culture, his epoch and his legacy. It is meticulously researched and documented and written with unfailing intelligence. The facts are little

contended. The analysis and interpretation – how to understand the facts – are endlessly debatable.

4. *Citizen Jane: Battle for the City*. Director, Matt Tyrnauer. Altimeter Films, 2016
   This is a recent and very accessible documentary film portraying the nature of Moses' culture and legacy and how it was eventually confronted and contained. This was due to the determined, deeply thoughtful courage of a highly articulate activist-campaigner and journalist, Jane Jacobs.

5. *The Death and Life of Great American Cities*. Jacobs, Jane (1961)
   Jacobs (1916-2006), though not an academic, contributed enormously to our observation and understanding of social life in cities and its relationship to planning and design. She wrote several related books: this is probably the most influential. The human sense and power of its arguments did much to, very belatedly, curtail Moses' imperial-like power. This encounter and its outcome became a twentieth century landmark in the history of social activism opposing institutional oligarchy.

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The many quotes, descriptions and historical fragments relating to Moses and his legacy throughout this essay have been gleaned from 2, 3, 4 and 5.

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6. For example, *Family and Kinship in East London*. Young, Michael and Willmott, Peter (1957)

   This sixty-year-old study remains universal and timeless in showing what makes sustainable bonds and meaning among poor city dwellers.

7. Pastoral Healthcare (PH) has, in many ways, become abandoned by the spectacular and accelerating success of Curative Healthcare (CH). Because of CH's successes – for example in surgery, vascular or infectious diseases – it has been adopted to template thinking, language and intervention models throughout healthcare. This has led to serious losses in our considerations of attachment and meaning – the idiomorphic – that are essential to PH.

   This matters enormously. Notwithstanding the rightful and extensive place and power of CH, there remain ineluctably vast areas where PH is much more apposite and effective. Stress-related illness (very common, but how can we agree on measurements?), degenerative and ageing conditions and dying are all, or almost, universal and unfixable. PH can make major contributions: CH hardly. Here we need the mindset of the sidewalk, not the Freeway.

8. 'Sidewalk losses' to our NHS healthcare have been grievous through the relentless serial modernisation programmes As with urban renewal, many human venues and activities have been speedily extinguished without their value being understood by planners (though understanding was often expressed, in vain, by patients and practitioners). To return to our surgical analogy, the process has often been akin to a surgeon who does not understand any anatomy apart from the target organ: he cuts surrounding tissues without cognisance or comprehension of what he is cutting.

Many of the losses derive from authority-driven imperatives for *ever-greater efficiency* by increasing scale, speed, systemisation, standardisation and specialisation. As with city modernisation this has usually resulted in the evisceration of personal and social bonds, affiliations and identifications. Such losses affect pastoral more than curative healthcare, but there are many exceptions.

An exhaustive list of such losses and what we might remedy would be so long as to be unreadable here. The following is merely a sampling, with some brief notes. There is inevitable overlap in the categories and comments.

- **Scaling-up for economy and standardisation**

  Examples: The closure of small 'family doctor' practices and their amalgamation into much larger centres, for 'primary care service provision'. Likewise the closure of many smaller locality hospitals, investing instead in enormous airport-like conurbations. Similarly, our now enormous amalgamated medical schools and university nursing departments.
  Losses: personal and environmental familiarity, more likely personal understanding and continuity of care, friendly interchanges, accessibility.

- **Schematisation, expedient mass-management and informatics**

  Examples: Abolishing personal lists for GPs, registering patients with a place rather than a person. The similar replacements of named consultant-led firms by more generic specialist 'teams'. Standardised tick-box procedures for diagnosis, care-pathways and more general management. Replacing locality Nursing Schools by university courses. The pre-eminence of data over language, of protocol over judgement, of quantification over personal understanding. Expanding the *REMIC* (remote management, inspection and compliance) culture to ensure the predictable obedience of all practitioners

and institutions: maintaining a constant pressure of instructions, briefings, appraisals and inspections.

Comment*: Loss of practitioners' headspace and heartspace, professional responsibility and capacity for wise and creative compromises. Vocational spirit perishes as corporational control advances. Likewise our subtle autonomy-within-community. Such cumulative alienation leads to now very evident institutional dispiritedness and sickness.*

Adding to the mix: formulaic, over-protocoled medicine tends to overdiagnosis, over-treatment, poor rapport with patients and yet more work.

Note the equivalent troubled symptoms between the erstwhile urban-renewed citizens and our current serially reformed healthworkers.

- **Increased access, speed and accuracy of all signalling and data handling**
  All healthcarers are now online and available to speedily receive and transmit with one another and with HQ. A benefit to all, surely?

  Comment: *Not necessarily. As with road building in our cities we can easily worsen our environment and merely attract more traffic – clearly a net loss. Our IT systems are, at least, and, in many ways, a mixed blessing: for example, the instantaneous and 'free' transmission of several very long missives to many recipients is very easy for the sender, yet burdensome for the recipient who, in recent years, is likely to spend increasing time and attention learning to speed-read and fillet an increasingly blizzard-like environment of ambient signals. Like the perversely traffic-locked city, we have succeeded in generating so much signalling that our better communication becomes very difficult, if not impossible. Many healthcarers report that the ever-increasing demands from IT devices seriously compromise their availability for personal clinical work and rich colleagueial contact.*

Like the tower-blocked, we become trapped by the density of devices constructed for our benefit. And in this entrapment we have generated a new scale and type of loneliness.

9. The text of this article was written before the shocking inferno of Grenfell Tower, West London in June 2017. Neglect of environmental hazard seems both equivalent and parallel to the human-ecological neglect considered throughout this article. The acute loss of many lives is, of course, more shockingly and dramatically tragic.

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Postscript

Shortly after writing *Déjà Vu* I am sitting with a senior NHS executive, attempting to interest him in the above history and ideas. He is certainly interested and seems attentively friendly and receptive, stroking his chin in contemplation.

He grimaces and sighs softly at the size of our problems, before pronouncing 'Well, I can see the problems. We certainly need more robust systems.'

'No!' I quickly shake my head. He has been very patient and now I am not. 'Don't you see? We need *less* systems, and whatever we have must be subtle rather than robust.'

He looks at me, taken aback, blinking and receding with incomprehension. Yes, I can see that he can see some of the problems. But his mindset? I fear it is closer to Robert Moses' than mine.

He wants to *fix* all this, and quickly.

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